GATES
Family Dentistry

Patient Name _____ Date of Birth _____

Preferred Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Cell _____ Email _____

SSN # _____ Gender ☐ Male ☐ Female Marital Status _____

Employer _____ Insurance _____

Person responsible for payment _____ Phone _____

Emergency Contact _____ Relationship _____ Phone _____

Referred by _____

PATIENT MEDICAL HISTORY

Have you been diagnosed with or had any of the following? ***(check all that apply):***

☐ Heart Disease
☐ Heart Attack
☐ Irregular Heartbeat/Rhythm
☐ Stroke
☐ Pacemaker
☐ Chest Pain (Angina)
☐ Heart Surgery
☐ Artificial Heart Valve
☐ Congenital Heart Condition
☐ High Blood Pressure
☐ Fainting/Dizziness
☐ Blood Thinning Medication
☐ Bleeding Disorder
If yes, please specify:

_____

☐ HIV+/AIDS
☐ Hepatitis B
☐ Hepatitis C
☐ Artificial Joint(s)
☐ Plate(s) or screw(s) in bones
☐ Head Trauma

☐ Osteoporosis/Osteopenia
☐ Bisphosphonate Treatment
If yes, please specify:
Years: _____ ☐ Oral ☐ IV/Injection
☐ Diabetes
☐ Insulin Treatment
☐ Thyroid Disease
☐ Liver Disease
☐ Kidney Disease
☐ Transplant Surgery
☐ Autoimmune Disease
☐ Cancer
If yes, please specify:

_____

☐ Chemotherapy
☐ Head/Neck Radiation Treatment
☐ Immune System Problems
☐ Respiratory/Lung Problems
☐ Asthma ☐ COPD
☐ Emphysema ☐ Tuberculosis
☐ Shortness of Breath
☐ Chronic Cough

☐ Sinus Problems
☐ Seasonal Allergies
☐ Seizures/Epilepsy
☐ Stomach Problems
☐ Acid Reflux/GERD
☐ Venereal Disease
☐ Sleep Apnea
☐ Jaw Joint Problems
☐ Anxiety Disorders
☐ Mental Disorders
☐ Addiction Problem/Opiates
If yes, please specify:

_____

Any other condition or treatment not listed above?

_____

_____

_____

Female Patients

Are you pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No Using birth control? ☐ Yes ☐ No

OVER

ALLERGIES

Are you allergic or had a reaction to any of the following? ***(check all that apply):***

- ☐ Penicillin
- ☐ Aspirin
- ☐ NSAIDS (Ibuprofen, Naproxen, Meloxicam, etc.)
- ☐ Latex
- ☐ Sulfa Drugs
- ☐ Local Anesthetics (Lidocaine, Novocaine, etc.)
- ☐ Codeine
- ☐ Iodine
- ☐ Morphine
- ☐ Food Allergy

  If yes, please specify: _____
- ☐ Other allergy not listed

_____

GENERAL MEDICAL/DENTAL QUESTIONS

Are you presently under the care of a physician? ☐ Yes ☐ No

If yes, physician's name _____ Phone _____

Have you ever been told by a physician that you require antibiotic pre-medication prior to dental treatment being performed? ☐ Yes ☐ No

Have you ever had any adverse reaction or effects from past dental treatment? ☐ Yes ☐ No

If yes, please explain _____

Date of last cleaning _____ **Date of last x-rays** _____

Have you had any serious illness, surgery, or been hospitalized in the last 5 years? ☐ Yes ☐ No

If yes, please explain _____

Do you currently smoke or use tobacco products? ☐ Yes ☐ No

Chief Dental Concern _____

Pharmacy _____ Phone _____

Please list ALL current medications and supplements _____

_____

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible. To the best of my knowledge, the above information is complete and correct.

_____

Signature of Patient, Parent, Guardian *Date*

_____

Printed Name of Patient, Parent, Guardian *Relationship*

_____	_____	_____	_____
Updated (Initials/Date)	*Updated (Initials/Date)*	*Updated (Initials/Date)*	*Updated (Initials/Date)*